

**Request for Referral Authorization or Prior Approval
Medical Procedures**

BCBSVT Prior Approvals (referral authorizations are not required for any product) should be faxed to: **(802) 371-3491**

New England Health Plan Referral Authorizations should be faxed to: **(802) 371-3491**

The Vermont Health Plan Prior Approvals should be faxed directly to one of the following:

Central Vermont PHO Providers: **(802) 371-4572** VMC Providers: **(802) 847-6213** TVHP: **(802) 371-3491**

SECTION 1: Patient Information		
Name (last, first, middle initial):		Other Insurance: Y/N
Date of Birth: ____/____/____	Patient Gender: Male/Female	Alpha Prefix and Certificate Number:
Primary Diagnosis:		Secondary Diagnosis:
SECTION 2: Referring Provider Information		
Name (last, first, degree) of provider requesting RA/PA:		Phone Number: ()
		BCBSVT Provider #:
SECTION 3: Proposed Rendering Provider		
Name (last, first, degree) of provider/facility who will render service(s):		Phone Number: ()
		BCBSVT Provider # (if provider does not have one, then full address):
SECTION 4: Please refer to the Quick Reference Grids to determine if Referral Authorization, Prior Approval or no action is required		
<input type="checkbox"/> REFERRAL AUTHORIZATION (to be used for New England Health Plan Members only)		
Requested # of visits: <input type="checkbox"/> Evaluate Only	First visit date: ____/____/____	CPT Code or procedure _____
Type of Referral (check one):		
<input type="checkbox"/> Ambulance (non emergent)	<input type="checkbox"/> Genetic Testing	<input type="checkbox"/> Out of Network
<input type="checkbox"/> Cardiac Rehabilitation	<input type="checkbox"/> Home Health/Hospice	<input type="checkbox"/> Podiatry Care
<input type="checkbox"/> Durable Medical Equipment	<input type="checkbox"/> Hospital Services	<input type="checkbox"/> Prosthetic Devices
<input type="checkbox"/> PRIOR APPROVAL		
Requested Service (please refer to prior approval grid for specific procedures, if procedure is not listed, PA is not required):		Provide any detailed clinical information pertaining to the procedure/service. Attach supporting documentation if necessary. If the requested service is out-of-network, please specify why these services can't be provided by an in-network provider:
First Visit Date/Proposed Admission/Procedure Date: ____/____/____		
CPT Code or procedure _____		
Check One of the following categories:		
<input type="checkbox"/> Ambulance	<input type="checkbox"/> Hospice Care	<input type="checkbox"/> Polysomnography & MSLT
<input type="checkbox"/> Capsule Endoscopy	<input type="checkbox"/> Medical Nutrition for inherited metabolic disease	<input type="checkbox"/> Private Duty Nursing
<input type="checkbox"/> Chondrocyte Transplant	<input type="checkbox"/> New Procedure still considered investigational or experimental	<input type="checkbox"/> Prosthetics
<input type="checkbox"/> Continuous Passive Motion (CPM)	<input type="checkbox"/> Orthotics	<input type="checkbox"/> Radiology
<input type="checkbox"/> Dental	<input type="checkbox"/> Out of Network (VHP & TVHP)	<input type="checkbox"/> Rehabilitation
<input type="checkbox"/> Durable Medical Equipment	<input type="checkbox"/> Osteochondral Autograft Transfer System	<input type="checkbox"/> Surgery
<input type="checkbox"/> Purchase Price of DME \$ _____	<input type="checkbox"/> Plastic/Cosmetic	<input type="checkbox"/> TENS Unit
<input type="checkbox"/> Endocrinology (CPT 95250 & 95251)		<input type="checkbox"/> Transplants
<input type="checkbox"/> Home Infusion Therapy		<input type="checkbox"/> UPPP/Somnoplasty
SECTION 5: Signature of Referring Provider & Contact Information		
Referring Providers Signature:		Date: ____/____/____
Referring Providers Name Written Out:		Phone Number: ()
Name of person to contact if questions regarding this form/recommended services:		

In order for a member to obtain coverage for a service, this form must be completed and faxed prior to the service being rendered. Completion of this form does not guarantee benefits.